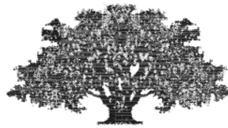

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Patient Registration

Patient Information

Patient Name: ____ Preferred Name:________________________________

Address, City, State, & Zipcode:____

____

____

Home Phone: _____________________ Work Phone: _______________________Ext: _____ Cellular: _________________

Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Birth Date: _______________ Age: ______ Social Security: __________________ Driver's License:___________________

E-mail: ____ ☐ I would like to receive correspondence via e-mail.

Primary Insurance Information

Name of Insured: ___________________________________ Relationship to patient: ☐ Self ☐Spouse ☐ Child ☐Other

Insured Social Security: __________________________________ Insured Date of Birth:___________________________

Employer: ______________________________________ Insurance Company:__________________________________

Address: _______________________________________ Address:____

City, State, Zipcode: ______________________________ City, State, Zipcode:___________________________________

Secondary Insurance Information

Name of Insured: ___________________________________ Relationship to patient: ☐ Self ☐Spouse ☐ Child ☐Other

Insured Social Security: __________________________________ Insured Date of Birth:___________________________

Employer: ______________________________________ Insurance Company:__________________________________

Address: _______________________________________ Address:____

City, State, Zipcode: ______________________________ City, State, Zipcode:___________________________________

Godley Station Dental

Eaglesoft Medical History

Patient Name: Birth Date: Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication

Question	Answer	
Are you under a physician's care now?	◯ Yes ◯ No	If yes
Have you ever been hospitalized or had a major operation?	◯ Yes ◯ No	If yes
Have you ever had a serious head or neck injury?	◯ Yes ◯ No	If yes
Are you taking any medications, pills, or drugs?	◯ Yes ◯ No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	◯ Yes ◯ No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	◯ Yes ◯ No	If yes
Are you on a special diet?	◯ Yes ◯ No	
Do you use tobacco?	◯ Yes ◯ No	

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin	☐ Penicillin	☐ Codeine	☐ Acrylic
☐ Metal	☐ Latex	☐ Sulfa Drugs	☐ Local Anesthetics

Other?	☐	If yes
Do you use controlled substances?	◯ Yes ◯ No	If yes

Do you have, or have you had, any of the following?

Condition	Answer	Condition	Answer	Condition	Answer	Condition	Answer
AIDS/HIV Positive	◯ Yes ◯ No	Cortisone Medicine	◯ Yes ◯ No	Hemophilia	◯ Yes ◯ No	Radiation Treatments	◯ Yes ◯ No
Alzheimer's Disease	◯ Yes ◯ No	Diabetes	◯ Yes ◯ No	Hepatitis A	◯ Yes ◯ No	Recent Weight Loss	◯ Yes ◯ No
Anaphylaxis	◯ Yes ◯ No	Drug Addiction	◯ Yes ◯ No	Hepatitis B or C	◯ Yes ◯ No	Renal Dialysis	◯ Yes ◯ No
Anemia	◯ Yes ◯ No	Easily Winded	◯ Yes ◯ No	Herpes	◯ Yes ◯ No	Rheumatic Fever	◯ Yes ◯ No
Angina	◯ Yes ◯ No	Emphysema	◯ Yes ◯ No	High Blood Pressure	◯ Yes ◯ No	Rheumatism	◯ Yes ◯ No
Arthritis/Gout	◯ Yes ◯ No	Epilepsy or Seizures	◯ Yes ◯ No	High Cholesterol	◯ Yes ◯ No	Scarlet Fever	◯ Yes ◯ No
Artificial Heart Valve	◯ Yes ◯ No	Excessive Bleeding	◯ Yes ◯ No	Hives or Rash	◯ Yes ◯ No	Shingles	◯ Yes ◯ No
Artificial Joint	◯ Yes ◯ No	Excessive Thirst	◯ Yes ◯ No	Hypoglycemia	◯ Yes ◯ No	Sickle Cell Disease	◯ Yes ◯ No
Asthma	◯ Yes ◯ No	Fainting Spells/Dizziness	◯ Yes ◯ No	Irregular Heartbeat	◯ Yes ◯ No	Sinus Trouble	◯ Yes ◯ No
Blood Disease	◯ Yes ◯ No	Frequent Cough	◯ Yes ◯ No	Kidney Problems	◯ Yes ◯ No	Spina Bifida	◯ Yes ◯ No
Blood Transfusion	◯ Yes ◯ No	Frequent Diarrhea	◯ Yes ◯ No	Leukemia	◯ Yes ◯ No	Stomach/Intestinal Disease	◯ Yes ◯ No
Breathing Problems	◯ Yes ◯ No	Frequent Headaches	◯ Yes ◯ No	Liver Disease	◯ Yes ◯ No	Stroke	◯ Yes ◯ No
Bruise Easily	◯ Yes ◯ No	Genital Herpes	◯ Yes ◯ No	Low Blood Pressure	◯ Yes ◯ No	Swelling of Limbs	◯ Yes ◯ No
Cancer	◯ Yes ◯ No	Glaucoma	◯ Yes ◯ No	Lung Disease	◯ Yes ◯ No	Thyroid Disease	◯ Yes ◯ No
Chemotherapy	◯ Yes ◯ No	Hay Fever	◯ Yes ◯ No	Mitral Valve Prolapse	◯ Yes ◯ No	Tonsillitis	◯ Yes ◯ No
Chest Pains	◯ Yes ◯ No	Heart Attack/Failure	◯ Yes ◯ No	Osteoporosis	◯ Yes ◯ No	Tuberculosis	◯ Yes ◯ No
Cold Sores/Fever Blisters	◯ Yes ◯ No	Heart Murmur	◯ Yes ◯ No	Pain in Jaw Joints	◯ Yes ◯ No	Tumors or Growths	◯ Yes ◯ No
Congenital Heart Disorder	◯ Yes ◯ No	Heart Pacemaker	◯ Yes ◯ No	Parathyroid Disease	◯ Yes ◯ No	Ulcers	◯ Yes ◯ No
Convulsions	◯ Yes ◯ No	Heart Trouble/Disease	◯ Yes ◯ No	Psychiatric Care	◯ Yes ◯ No	Venereal Disease	◯ Yes ◯ No
						Yellow Jaundice	◯ Yes ◯ No

Have you ever had any serious illness not listed	◯ Yes ◯ No	If yes

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X Date:__________

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Financial Arrangements

Optional Payment Terms:

- Full Pay Cash Discount: We offer a 5% accounting courtesy for all treatment over $500 that is paid in full prior to the commencement of treatment.
- Full Pay Credit: We accept full or partial payment by Visa, MasterCard, American Express, or Discover.
- Term Loan: By arrangement with Care Credit, we can offer our patients, upon approval, an interest-free loan *(up to 12 months)* with no down payment, no annual fee, and no prepayment penalty. Ask for an application.

There will be a fee for any additional procedure(s) NOT included in the original treatment plan.

Payment Policies
To maintain the practice operation and to prevent potential misunderstanding, we ask patients to accept and adhere to financial arrangements regarding their dental treatment. Payments are expected at the time services are rendered. We accept cash, check, check cards, and all major credit cards. Any treatment estimated above $300.00 must be accompanied by a specific financial arrangement.

Dental Insurance
We are happy to assist you in filing the necessary forms to help you receive the full benefits of your coverage; however, we can make no guarantee of any estimated coverage or payment. Because the insurance policy is ***an agreement between you and your insurance company,*** we ask that all ***patients be responsible directly for all charges*****.** Please know we will do everything possible to see that you receive the full benefits of your policy.

I understand that if my account has been turned over to a third party collection agency for non-payment, there will be a collection fee added to my bill of thirty five percent *(35%)*, pursuant to Georgia Statutory Law *"O.C.G.A.-13-1-148."*

Patients are responsible for the full amount of their bill.

Broken Appointments
Your appointment is time that has been reserved especially for you and we strongly encourage all patients to keep their appointments. If you must change your appointment, we require **a minimum of 48 hours notice** to avoid a cancellation fee.

I, ______________________________________, understand and agree to the above financial policy.

Patient's or Responsible Party

Party's Signature ____ Date: ________________________

Financial Officer: ____ Date: ________________________

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Patient Name:____**Date of Birth:**____________________

Our office is unique and unlike any dental office you have ever been to. Your upcoming visit is an important step towards your dental wellness. Please answer the following questions so that we may better serve you.

- Do you have any areas of concern? ☐Yes ☐No If yes please explain. ______________________________
  ____
- What do you think the current state of your oral health is? ☐good ☐fair ☐poor
- What would like to improve about your smile? ____
  ____
- Has fear ever been an issue for you in a dental office? ☐Yes ☐No
- Have you ever needed to take an analgesic prior to treatment? ☐Yes ☐No
- Have you ever needed to use the following for dental treatment? *(Check all that apply)*
  ☐Nitrous Oxide ☐Mild Sedative ☐Moderate Sedative
- When was your last visit to the dentist? ____
- Have you ever been diagnosed with periodontal disease? ☐Yes ☐No
- Do you have any of the following? *(check all that apply)*
  ☐jaw pain ☐popping of the jaw ☐jaw soreness ☐trouble opening your mouth wide?
- Do you have or have ever had a night guard or mouth splint? ☐Yes ☐No
- Do you usually suffer from seasonal allergies or sinus problems? ☐Yes ☐No
- Do you snore? ☐Yes ☐No
- Are you tired, fatigued, or sleeping during the day? ☐Yes ☐No
- Do you ever choke or gasp while you sleep? ☐Yes ☐No
- Have you had an overnight sleep study? ☐Yes ☐No
- Do you have a CPAP? ☐Yes ☐No
- Do you use your CPAP? ☐Yes ☐No
- Why did you leave your last dental office? ____
- What additional information would you like us to know? ______________________________________
  ____
- How did you find out about our office?
  ☐Personal referral from ____
  ☐Mail Flyer ☐Newspaper ☐TV ☐Facebook ☐Internet/Internet Search

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Our goal is to help you take care of your teeth, smile, and mouth at a level that is right for you. In our practice, we believe that the level of care that you want is your choice. We will help you thoroughly understand your dental choices so you can make the best possible decision. Your first choice is how you would like us to work with you. Please consider the following guidelines for care so that we can best meet your goals. Which of the following levels of care do you prefer?

☐**Level 5: Optimal Dentistry**
Just like complete dentistry patients, patients at this level are focused on long-term dental health and disease prevention, but they also want their teeth and smile to look great. Patients at this level are interested in treatment options to correct all dental concerns for lifelong optimal function and appearance. For some of these patients enhancing their appearance with a beautiful new smile is very important. Optimal dentistry patients are dedicated to do more then what their insurance allows in a year.

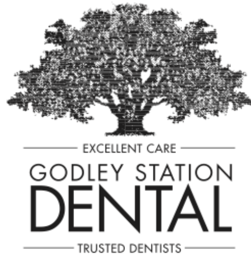
☐**Level 4: Complete Dentistry**
Complete dentistry patients are concerned about the current conditions in their mouth, the causes of dental disease, and their long-term health. They want to know their full treatment options so they can become and remain as healthy as they can be, thereby minimizing their long-term dental costs. These patients often choose a step-by-step master plan focused on restoring their health, combined with prevention and regular care to achieve steady long-term dental health and an improved appearance to their smile over time. Complete dentistry patients are dedicated to do more then what their insurance allows in a year.

☐**Level 3: Proactive Care**
Patients at this level seek treatment for existing concerns just like remedial care patients, but they are also concerned about conditions that may create problems in the near future. These patients generally want to maintain the health of each tooth at a basic level, so they also do what they can to prevent new concerns from developing. When treatment is recommended proactive care patients usually prioritize their treatment to manage their costs, but still take care of things soon enough so that known concerns are less likely to develop into major problems. Proactive care patients are usually interested in maximizing what their insurance allows in a year.

☐**Level 2: Remedial Care**
Patients at this level choose treatment for obvious problems such as broken or cracked teeth, cavities, sensitivity, discomfort, or concerns that are creating issues in the mouth right now. Remedial care patients are usually not focused on taking steps to prevent new concerns or improve their health over time. They only want to deal with concerns that have already developed into conditions that require treatment to remove existing disease or repair the teeth back to the most basic level of health. Remedial care patients are usually only interested in doing treatment that their insurance allows in a year.

☐**Level 1: Urgent Care**
Patients at this level choose treatment only when they experience a crisis such as pain, swelling, or bleeding that requires immediate treatment. Urgent care patients are generally not focused on taking steps to ensure future urgencies do not occur. They come in when they know they have a major problem to deal with and the condition has developed to a point of urgency in order to control pain or save the tooth.

It is not uncommon for people to begin at one level and progress to higher levels when they are ready. We are here to help you discover what is right for you so your teeth, smile, and mouth remain as healthy as they can be or life based on your goals.



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Office Procedures

1. Phone Confirmations: It our procedure that you call 24 hours in advance to cancel your appointment or there will be a charge of $55.

2. Verbal Authorization: It is our office procedure to get verbal authorization from all new patients to confirm appointments and leave messages if patient is not available. Also, patient must call 24 hours in advance to cancel appointments. It is also our procedure that we get your insurance information so we can confirm the status of your insurance and get prior authorization for treatment as needed.

3. It is our office procedure that we mailed reminder postcards that say, when your next hygiene appointment is scheduled or that remind you when you are due for your next hygiene appointment.

4. I authorize the following person/persons to be my personal representative, which means the doctor and staff may speak freely to the named personal representative regarding all my Protected Health Information, Medical and Treatment matters and Billing.

Name	**Relationship**
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________

______________________________ ______________________________
Patient's Signature Date

5. I authorize the following named person/persons to authorize medical treatment for my named children. The Doctor and staff may speak freely regarding my child/children's protected health information, medical treatment matters and billing. I understand that I am still responsible for the billing.

Name of Authorized Person/Relationship	**Children's Name**
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________

______________________________ ______________________________
Patient's Signature Date

6. I, ________________________, authorize this facility to examine and provide medical treatment. I assume full responsibility for any balance due. I authorize my insurance company to pay by check made out directly to this facility. I authorize this facility to release any medical or incidental information that may be necessary for either medical care or in processing applications for financial benefit. I understand it is my responsibility to know all rules and restrictions of my insurance policy, to know which hospital, emergency rooms, laboratories, x-ray departments and specialists and specialist providers which are assigned to me according to my insurance policy rule. It is this facility's procedure to share Protected Health Information with labs, x-rays, consulting physicians, and hospitals. We will call the pharmacy of your choice regarding your prescriptions. We will only exchange minimum necessary Protected Health Information for each transaction.

7. Our office is HIPAA-compliant and the staff has been trained in the HIPAA Privacy Act. We will do everything we can to protect your Patient Health information.

However, our office was designed before the HIPAA Law so please be respectful of other patients' privacy.
I, ______________________________________ (patient's name), agree to all of the above office procedures of this facility, and give my authorization to all of the above procedures.

Patient's Signature:____________________________________
Date: ____

List names of minor family members and their ages:
____

Spouse: __________________________

____

Date: __________________________

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Acknowledgment of Receipt of HIPAA Notice of Privacy Practices ("Acknowledgment")

I acknowledge that I have received a copy of the Dental Practice's **HIPAA Notice of Privacy Practices.**

Patient's Name (Please Print) ____

____

Patient Signature or Signature of Personal Representative

____

Date

Authority of Personal Representative to Sign for Patient (Check one):

☐Parent ☐Guardian ☐Other: ____

Please note: It is your right to refuse to sign this acknowledgment.

Dental Office Use Only

I tried to obtain written Acknowledgment by the individual noted above of receipt of our **Notice of Privacy Practices,** but it could not be obtained because:

☐An emergency prevented us from obtaining acknowledgment.
☐A communication barrier prevented us from obtaining acknowledgment.
☐The individual was unwilling to sign.

Other: ____

____________________________________ ____________________________________

Office Representative's Signature Date